

Dental Report and Estimate

PLEASE COMPLETE BOTH SIDES OF THIS FORM AND RETURN IT TO THE ADDRESS ON THE REVERSE.

Name of Health Care Provider (please print)				WSCC Claim Number			
Address (include postal code)				Worker's Last Name First Name			
Telephone (include area code)				Postal Address (include postal code)			
Incident/Injury Date				Residential Address			
Examination Date				Telephone (include area code)			
Employer's Name				Date of Birth			
				Worker's Occupation			

1. Who rendered first treatment?

2. Date you first treated.

YYYY MM DD

3. What does worker say caused the injury?

4. Describe damage resulting from incident. If damage is to dentures, please describe.

5. Please mark chart using the following symbols:

- ➔ Teeth damaged by accident
- Teeth to be extracted as a result of the accident (colour in the tooth)
- X Teeth missing (prior to accident)

6. Describe any other oral condition that may be present, with your opinion as to whether or not it is due to the incident in question. If necessary, x-ray injured areas and give radiological report.

7. Describe in detail, your treatment plan to restore, as nearly as possible, the masticatory function to the degree existing prior to the accident.

The diagram shows a dental chart with two arches: UPPER and LOWER. The teeth are numbered 1-1 to 1-8 on the upper arch and 4-1 to 4-8 on the lower arch. The chart is labeled with 'Right' and 'Left' for the patient's perspective, and 'Permanent' for the type of teeth. The chart is used to mark teeth damaged by accident, teeth to be extracted, and teeth missing prior to the accident.

8. Estimate in detail, the entire treatment plan with itemized charges, using your Dental Association Fee Schedule.

_____	\$ _____
_____	_____
_____	_____
_____	_____
_____	_____
Total \$ _____	

Health Care Provider's Signature _____

THIS IS AN ESTIMATE ONLY - NOT TO BE CONSIDERED AN ACCOUNT

Signature of person completing form _____ Date

____	____	____
YYYY	MM	DD

RESPONSIBILITY OF HEALTH CARE PROVIDER

Excerpts from the Nunavut & NWT *Workers' Compensation Acts*

Report by health care provider	25. (1)	A health care provider who examines or treats a worker under this Act shall submit a report to the Commission.
Timing and contents of report	(2)	The report must be submitted within three days after the examination or treatment, and must contain the information required by the Commission.
Duty of health care facility	(3)	If a health care facility employs the health care provider referred to in subsection (1), the health care facility is responsible for ensuring that the report is submitted in accordance with this section.
Provision of information	30.	The Commission may require a claimant, an employer or a health care provider to provide any information that it considers necessary for it to determine a claim for compensation.

Excerpt from the Nunavut & NWT *Workers' Compensation General Regulations*

- 7.2 A health care provider who fails to provide information required under section 30 of the Acts is liable under subsection 141(2) to a penalty of \$250.

The WSCC may use this information for the administration of legislation under our authority, including the *Workers' Compensation Acts*, the *Safety Acts*, and/or the *Mine Health and Safety Acts*, and their associated *Regulations*, and to contact you in relation to the requirements under the relevant legislation. It is your responsibility when providing an email address to ensure reasonable safeguards are in place to protect the confidentiality and security of your personal information within your email account.

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